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U.S. ARMY - BAYLOR UNIVERSITY  
GRADUATE PROGRAM IN HEALTH CARE ADMINISTRATION

ESTABLISHING AN EFFECTIVE  
PREADMISSION CERTIFICATION PROGRAM  
IN A NAVAL MEDICAL CENTER

A GRADUATE MANAGEMENT PROJECT  
PRESENTED TO

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THE MASTER OF SCIENCE DEGREE IN  
HEALTH CARE ADMINISTRATION

BY

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PORTSMOUTH, VIRGINIA

MAY 13, 1994

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During the past two years, I have been fortunate to be associated with thirty five of the finest graduate students ever assembled. The depth and breadth of experience each brought to the classroom will not be equalled. Together we worked and played hard - looking to the uncertain and exciting future of health care.

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## ABSTRACT

Resources for Department of Defense health care delivery are diminishing. Consequently, the Naval Medical Center Portsmouth must find ways to stretch funds while continuing to provide quality health care to eligible patrons. One cost containment mechanism is third party payer preadmission certification for patients requiring hospitalization.

This case study was conducted through review and analysis of documents, internal and external to Naval Medical Center Portsmouth, including operating procedures, instructions, memoranda, letters, and published literature.

The Naval Medical Center Portsmouth, Virginia preadmission certification process was fragmented because:

- (1) the clinical staff was inadequately educated in the economical benefits of such a program
- (2) ineffective communication between the medical, nursing, administrative, and resource management staffs created confusion and fostered conflict regarding implementation of the preadmission certification program
- (3) locations of the various departments created physical and artificial barriers to effective communication and implementation, and
- (4) each department had specific operating procedure that did not consider requirements of other affected areas.

The addition of a preadmission certification processor has improved the reimbursement level from third party payers because patients are admitted for medically necessary care or seen at other sites determined to be medically (using InterQual ISD-A criteria) and economically appropriate.

Communication has improved in that the medical, nursing, administrative, and resource management are willingly and openly discussing issues that cross professional and personal boundaries in the health care delivery system.

Further research is required to determine the efficacy of the preadmission certification process as a utilization management tool. Additionally, implementation of total case management should be considered to facilitate active collaboration of the delivery team members and encourage appropriate use of medical facilities and services, improve the quality of care and maintain cost-effectiveness on a case-by-case basis.

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ESTABLISHING AN EFFECTIVE  
PREADMISSION CERTIFICATION PROGRAM  
IN A NAVAL MEDICAL CENTER

CHAPTER 1  
INTRODUCTION

Background

The United States participates in a competitive global economy where all factors of production (including health care costs) are constantly watched by profit-conscious managers. The consumer is no longer shy or uneducated and desires every benefit that medicine can provide. In the United States, health care costs are largely incurred by individuals and by various forms of third party provider organizations.

The growing federal deficit combined with the aging population has increased public awareness regarding health care cost containment. The President's desire to provide all citizens guaranteed access to quality health care is challenging the health care delivery system. In concert with President Clinton's campaign promise to reduce big government, Cabinet level programs are being reviewed for potential funding reductions.



The lack of a global military threat to the United States places national defense in an indefensible position. Money that has been relatively free flowing is reduced and actions of the Base Realignment and Closure Commission clearly mandate that the days of traditional business practices are gone. In fact, tri-service base closures are now acceptable. The "right sizing" of the military involves reductions in the number, size, and resourcing of the operational forces as well as the medical support functions. For example, the Naval Training Center in Orlando, Florida is closing and the hospital will cease operation by July, 1995.

The military health care system serves nearly 9 million beneficiaries with 400,000 active duty, reserve, and civilian personnel in 148 hospitals, 554 medical clinics, over 300 dental clinics, hundreds of medical activities assigned to operational units, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Health care expenditures (\$15 billion) comprised about 5.6% of the Department of Defense (DoD) budget in fiscal year 1993 (Lanier and Boone, 1993).

The health care environment is characterized by increasing costs, changing demographics, and limited budgets. Although the reasons for the rapid escalation of health care costs are both complex and myriad, one specific contributor is the financial system. The DoD historically

has used resource consumption levels and workload data to determine the amount of money a particular hospital receives annually. This funding base is then modified to incorporate known program changes such as opening (or closing) a family practice clinic.

When resources are limited, this method of funding may lead to inaccurate workload reporting which results in operational inefficiencies. A hospital receiving funds based on the number of patient visits may redefine a visit. For example, a patient receiving multiple immunizations is counted as a single visit. To artificially increase the number of visits, the hospital might record multiple visits for a single immunization for the same patient care episode. The end result is the number of visits has increased while the actual services provided have remained constant. To accurately document each of the immunizations, the amount of time the staff is unavailable for other patient care activities increases.

An unnecessary increase in the number of admissions for procedures and treatments that can be performed on an outpatient basis or in the home represents another operational inefficiency. By admitting the patient, the hospital staff is unavailable for patients requiring a higher intensity of service based on established severity indices such as the Interqual Standards. Consequently, other physical resources (supplies, durable medical equipment,

etc.) are expended in the "optional" provision of care making them unavailable to patients with documented medical requirements.

The real and forecasted changes within the DoD create a need to transition from a resource consumption and workload based funding system to a modified capitation based methodology. This means the Commander, Naval Medical Center Portsmouth, Virginia assumes responsibility for providing health services to a defined population for a fixed amount of money per beneficiary. Regardless of the degree of health services consumed, there is no financial incentive to inappropriately increase the number of services or provide more costly care than is clinically appropriate.

As a teaching hospital, Naval Medical Center Portsmouth provides formal education for multiple healthcare specialties and support programs. To meet program requirements, specific criteria must be achieved and learning experiences provided. It is important to recognize that the existence of training programs does not justify the delivery of unnecessary medical care. In fact, such a program requires development and use of specific treatment protocols and cost containment tools to provide appropriate care at the appropriate level in the health care delivery system.

On the premise that Naval Medical Center Portsmouth will prospectively receive the capitation amount, the

Commander is unable to influence the amount of money received for care during the fiscal year. As a result, the Commander is encouraged to deliver care in the most cost-effective setting, provide preventive services to minimize the need for acute health care, and carefully monitor service to evaluate the effectiveness of resource utilization.

The Naval Medical Center Portsmouth provides a comprehensive range of emergency, inpatient, and outpatient services to active duty members of the Navy, Marine Corps, Army, Air Force, Coast Guard, and the other uniformed services. Subject to the availability of resources and space, Naval Medical Center provides the maximum range and amount of comprehensive health services possible for other authorized users as prescribed under Title 10 U.S.C. 1095, and other applicable directives.

As the DoD medical lead agent for Region 2 (Appendix A), the Commander of Naval Medical Center Portsmouth is responsible for maximizing the use of all direct care assets in eight military treatment facilities (3 Navy, 3 Army, and 2 Air Force) in Virginia and North Carolina, in support of approximately 870,000 beneficiaries. The Commander also supplements that care by developing competitive contracts in conjunction with DoD (Health Affairs).

Only the hospital Commanders are authorized to make decisions regarding direct care funds or human resource

issues in their facility. However, the lead agent manages the regional Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds, coordinates tri-service issue of medical non-availability statements, and approves referral processes within the integrated Health Service Region network to improve resource use.

In fiscal year 1993, the Naval Medical Center Portsmouth budget was in excess of \$137 million dollars. Fiscal year 1994 funding will approximate \$148 million dollars. While this amount is higher than the 1993 funding level, money available for direct care is actually less given the increases in contract and supply costs. Section 2001[a][1] of Public Law 99-272 (The Consolidated Omnibus Budget Reconciliation Act of 1985) permits the DoD to collect from third party payers for "reasonable hospital costs incurred on behalf of most DoD health care beneficiaries." Congress believes that third party insurance plans should not deny payment for health care solely because beneficiaries are seen in a military hospital on a space available basis.

To facilitate participation of the hospitals, Congress modified the law in 1989 to allow hospitals to keep monies collected from third party payers instead of it being deposited into the general treasury of the United States. In 1990, 10 U.S.C. 1095 was modified to allow outpatient billing and collection from Medicare supplemental insurance

policy carriers, automobile liability, and no-fault insurance carriers for treatment of eligible beneficiaries in military treatment facilities.

#### Problem Statement

The current method of pre-admission certification, defined as non-physician utilization review assessment of a physician's plan of treatment and/or the proposed schedule of procedures or treatments prior to a patient's admission, is ineffective and inefficient. The purpose of such a review is to assure that the patient's admission to the hospital is medically necessary (compared against severity of index and intensity of service guidelines), that the services cannot be provided safely and effectively in a less intensive setting, and unnecessary delays in the proposed schedule for treating the patient are avoided.

In fiscal year 1992, failure to obtain pre-admission authorization meant third party payers denied 3.65% of every dollar billed by Naval Medical Center Portsmouth. Applying that same denial rate to fiscal year 1993, Naval Medical Center Portsmouth anticipated an inability to collect at least \$300,000.00 from third party carriers. Conservatively, 70% of the money denied would have been received by Naval Medical Center Portsmouth if appropriate utilization review/utilization management tools such as pre-admission certification were employed prior to patients

being admitted to the medical center.

Factors contributing to the ineffective preadmission certification program include inadequate education of the clinical staff concerning the economic benefits of the program; confusion and conflict between the medical, nursing, administrative, and resource management staffs created by ineffective communication of program goals and objectives; physical and artificial barriers to effective communication that precluded implementation of the preadmission certification program, and department specific operating procedures that do not consider requirements of other affected areas.

#### Literature Review

The Clinton Administration is focusing unprecedented social, political, and environmental pressures on health care issues. The call for health care reform is causing national health industry leaders to look fervently for alternatives to current methods of health care provision and financing.

In his 1974 book Who Shall Live? Health, Economics, and Social Choice, Victor Fuchs categorizes medical system problems as cost, access, and choice. Attributing health care cost increases to hospital inefficiencies and physician care, he describes the rise of medical expenditures in terms of technological advances and implementation of the Medicare

and Medicaid programs. Access for the poor, rural, homeless, and uneducated is specifically limited due to financial barriers, lack of insurance, and undistributed care. Choice relates to the life style alternatives people select which affect their physical and mental well being.

Today, pressures for health care reform include cost, access, resource allocation, and unnecessary care (Southby 1993). By the year 2000 health care spending growth (projected at an average annual rate of 9%) is expected to reach \$1.5 trillion, or 15% of the GNP. This equates to more than six times the amount spent on health care in 1984 (Pratt 1992).

What does this mean? The health care industry must examine itself for effectiveness and efficiency, continue services it performs well and delete inefficient and ineffective practices. The hospital should only provide medically necessary and appropriate care to maximize reimbursement from third party payers. Yet the hospital is both a community service organization and a business. If the hospital fails financially due to poor business practices, it will be unable to meet community needs (Hofmann 1993).

To minimize the possibility of financial failure, active collaboration must occur between providers, business leaders, patients and the government to identify and address common health care concerns.



The physician is critical to the effective operation of hospitals and remains the most prominent player in medical decision making. Increasingly, the physician is requested to share the responsibility of decision making with health care policy makers and consumers who bring values, priorities, and purposes to the decision process (Geller 1993). Brooke (1992) confirms the necessity for physicians to be partners in strategic, financial, and programmatic decision making for the hospital. Fuchs (1974) concludes that cooperation and collaboration among all parties involved in health care delivery is necessary to improve access, reduce cost, and enhance health levels.

Eventually everyone will seek some form of health care. Whether they rely on public programs, private pay, employer provided insurance or third party carrier, each consumer has a personal perspective of the health care delivery system and its ability to meet their needs (Brooke 1992; Ehreth 1993; Geller 1993; Hiatt 1987; Hurley and Thompson 1993; Smith 1992; and Tan, McCormick and Sheps 1993).

The federal health system cannot escape the harsh realities of cost containment under health care reform. As described by Lanier and Boone (1993), the military must decide "how to best organize resources to provide timely access to quality care and achieve economies at a time when civilian health care is itself in turmoil to improve access to quality care, achieve economies, and maintain (not

reduce) the health care benefit." To effectively use each health care dollar, the federal health system must actively pursue cost containment strategies such as preadmission certification and case management.

Lingering concerns over the cost of health care and indications that a significant portion of health care services may be medically unnecessary are forcing third party payers to demand Utilization Review provisions in which emphasis is placed on appropriateness, duration, and intensity of care through prospective, concurrent, and retrospective case review (Pratt 1992; Smith 1992; Tan, McCormick and Sheps 1993).

The Utilization Review process typically requires the provider to request authorization from a non-physician reviewer prior to admitting the patient. If standard screening criteria are met, authorization for a particular treatment regimen, treatment site or a specific number of hospital days is provided by the reviewer.

Preadmission authorization from the third party payer helps ensure the hospital receives maximum reimbursement for services (Baschon 1992). Conversely, the third party payer does not authorize admission for inappropriate, unfunded treatments that are better suited for an outpatient setting.

Concurrent review addresses Length of Stay monitoring during the course of treatment and corresponds directly with Diagnosis Related Group standards under CHAMPUS. Feedback

enables physicians to assess the financial impact of their treatment decisions in concert with quality of care considerations.

Retrospective review occurs following patient discharge. Common forms include peer review in which care and outcome are evaluated against standards of care, and financial where total care expenditures are collected and compared to the total DRG weight recorded by the hospital. This helps determine appropriateness of resource consumption on a DRG basis to facilitate further investigation or reward (Tan, McCormick and Shep, 1993).

#### Purpose

The intent of this study is to analyze and evaluate the existing preadmission certification program at Naval Medical Center Portsmouth in terms of compliance with utilization review and utilization management tools and the third party collection program. The findings will be used to provide recommendations for system improvements to the Naval Medical Center Portsmouth Commander.

## CHAPTER 2

### METHODS AND PROCEDURES

The research method selected for this project is a case study. Although the case study is a pre-experimental design, it is the appropriate research form when seeking answers to "why" or "how" questions when the investigator has little or no control over the process being analyzed (Sypher, 1990; Yin, 1989).

Potential advantages of a case study include generation of information that may lead to hypotheses formulation, clarification of the concepts and variables for further study, and discovery of ways to measure the variables. The primary disadvantage of a case study is the inability to generalize findings to a larger population based on the narrow focus.

This case study was conducted through review and analysis of documents, internal and external to Naval Medical Center Portsmouth, including operating procedures, instructions, memoranda, letters, and published literature.

Documents were reviewed and analyzed to evaluate the effectiveness of the existing preadmission certification program, describe events leading to recognition of need to improve the process, and determine how to implement the revised procedures. Additionally, data was gathered through

structured and unstructured interviews with Naval Medical Center Portsmouth staff members and participant observation to facilitate the investigator's understanding of the Naval Medical Center Portsmouth policies and procedures.

Research design quality is evaluated according to four relevant tests of logic: construct validity, internal validity, external validity, and reliability (Yin, 1989). Construct validity involves gathering empirical evidence to support the inference that a particular measure has meaning. It is appropriate when criterion inadequately define the phenomena to be measured. Construct validity is insufficiently tested by a single procedure. It requires evidence from multiple sources and becomes a matter of degree versus the property being either present or absent. Surveillance over time is necessary to determine if the phenomena changes. This study will use a variety of information sources to reduce measurement error on the part of the investigator, respondents, environment, and instrument.

Internal validity seeks to establish a causal relationship based on the experimental treatment effect. The concern in qualitative research is that of a researcher making unfounded inferences. External validity is concerned with generalization of the findings beyond the immediate case study.

Reliability refers to precise measurements of selected

variables to allow replication of the study and yield consistent results (Kirk and Miller, 1986). The goal of reliability is to minimize errors and bias in a study (Yin, 1989). Reliability is a necessary condition for validity. An instrument incapable of reproducing results cannot measure accurately. As a result, there is no validity. The reliability of this case study is dependent on maintenance of documentation by the researcher and the documents themselves.

The unsequenced case study described here provides flexibility to the researcher in describing dynamic organizational structures (Marshall and Rossman, 1989; Yin, 1989). As in all research, it is important the researcher remember the outcome should have applicability to the real world as well as academia.

## CHAPTER 3

### RESULTS

At the onset of the case study the medical center approach to the admission process appeared fragmented in terms of responsibility. Each functional area reported to the Commander via the Deputy Commander, Director of Administration or the Director of Resources (Appendix B).

This fragmentation provided an environment in which confusion and conflict grew because the responsible parties had different operating practices, principles, and desired outcomes. Consequently, interpersonal conflicts surfaced as efforts to reach resolution on the most appropriate course of action for implementation of the preadmission certification program increased in intensity.

There was no single document that described the actual admission/preadmission process and no one department knew all of the areas of responsibility related to implementation of the preadmission certification program. Third party collection interests were fiduciary; admissions sought to improve the flow of patients through their department; and utilization management and discharge planning were concerned with meeting the Interqual criteria for admission and continued stay reviews.

In the first month of operation, the preadmission certification processor reviewed 21 patients presenting for admission with third party insurance. Of the 21, 15 admissions were fully authorized, 4 were partially authorized, and 2 were denied entirely. The four were partially denied due to a convalescent day (1), a diagnostic day (1), and preoperative admissions the day before surgery (2). The complete denials resulted from a patient having a preexisting condition (1) and admission to a non-Health Maintenance Organization hospital (1).



## CHAPTER 4

### DISCUSSION

The initial involvement of the researcher was to determine what actually existed in the way of directives and guidance related to the preadmission certification process. This was accomplished through extensive review of the Naval Medical Center Portsmouth central files for instructions and notices related to the third party collection system, the admission process (including preadmission), and utilization management criteria.

Following a thorough review of each instruction, the individuals responsible for performing the functions identified in each instruction were contacted to determine the actual process in place. Using their input, process flow charts were prepared for generic, ambulatory, and obstetrical admissions (Appendix C), the patient administration quality improvement division (Appendix D), and the patient billing and collection process (Appendix E), using Flow Charting 3 (version 1.11) software.

The flow charts were reviewed by and discussed with the responsible parties to ensure they accurately depicted the conduct of the actual procedures. The interrelationships of the processes were explored at each level of Naval Medical Center Portsmouth to ensure the people had a working

knowledge of the entire process beginning with the credentialed provider's decision to admit the patient through the admission process, receipt of treatment, discharge, billing, and collection.

Prior to hiring the Preadmission Certification Processor, the generic admission process (Appendix C, Process One) required the patient to complete a active duty or non-active duty admission packet. The non-active duty packet contained a DD-2569, Insurance Information form which was completed and returned to the admissions clerk. The information was not routinely verified with the patient nor was the designated third party carrier called for admission authorization. Similar system failures occurred for the Ambulatory Procedure Unit and preadmission to Labor and Delivery (Appendix C, Processes One-A and B, respectively). The AQCESS/CHCS generated patient index cards are distributed as follows:

- 1 to Patient Administration Quality Improvement (Process 2)
- 1 to Communications (active duty only)
- 1 to Patient Mail Room
- 1 to Utilization Management
- 1 to Collection Agent (Process 3)
- 1 to 6300/7 and placed in patient record

The Patient Administration Department Admissions/Dispositions Quality Improvement Process (Appendix D, Process Two) begins when the patient index card is compared to the ward nursing report and the CHCS Daily Admission Report. Each subsequent report is prepared from

selected fields of the source documents. Upon discharge of the patient, the patient index card originally attached to the 6300/7 and placed in the patient medical record is removed and attached to the Admission/Disposition Report which is forwarded to the Third Party Billing and Collection Office (Appendix E, Process Three).

The Third Party Billing and Collection Office picks up the Admission/Disposition Report, the two patient index cards, and the DD-2569 Insurance Information forms from the Admissions office. The two patient index cards are filed after verification of the information on the Admission/Disposition Report. The DD-2569 is reviewed for accuracy and completeness, carrier coverage and restrictions are verified. The Admissions/Dispositions Report is reviewed for patient discharges, account write-offs, etc and compared with third party coverage information before a bill is generated. The collection process is completed when the account is paid in full by the carrier or patient.

The territorial issues described previously precluded development of a central repository for information related to the preadmission certification process. With emphasis on cost containment and active collaboration, case study focus shifted from functionally specific responsibilities to team problem solving.

The Deputy Commander and the Directors for Administration and Resources fully supported the case study.

Their staffs provided unlimited access and cooperation to the researcher to determine the requirements for establishment and implementation of an effective pre-admission certification program for the Naval Medical Center Portsmouth.

Prior to this study, Naval Medical Center Portsmouth did not have an identified person to perform preadmission certification (or continued stay review certification). By default, utilization management staff members became the initial contact for third party payers. In many situations, this occurred after the patient had been discharged from the hospital which required significant research (and expenditure of command resources in terms of time and opportunity costs) to determine if the admission properly met clinical criteria for the payer.

In October, 1993 the Head, Accounting Department, Naval Medical Center Portsmouth presented a cost-benefit analysis that identified the need to reduce the third party insurance denial rates (Appendix F). This resulted in the acquisition of numerous position description classifications from Army and Navy Commands. This data was used in the preparation of a tailored position description for a Preadmission Certification Processor at Naval Medical Center Portsmouth (Appendix G).

The Director for Resources requested and received authority to hire a preadmission certification processor

from the Naval Medical Center Portsmouth Board of Directors in early November. On February 1, 1994 the servicing civilian personnel office classified the position at the GS 7/9 level and began recruiting in the local geographic area. A qualified candidate was selected March 6, 1994, beginning work on March 25, 1994.

Physical space was another consideration in establishing the position. The physical location of the incumbent was a major concern in providing customer service. It was imperative the preadmission certification processor be accessible to the patients to enable collection of accurate insurance information. This personal contact allows a call to the third party carrier while the patient is available to provide additional information concerning their policy specifications.

Representatives from resources, admissions, and utilization management met to establish protocols and discuss issues of concern to minimize the disruption of service for the patient. The decision to place the preadmission certification processor in the Admissions/Dispositions Office was determined to be the most effective location within the hospital to meet the needs of the patient and staff alike.

An additional problem identified early in the study was the management information system used for patient admissions. The Automated Quality of Care Evaluation

Support System (AQCESS) was in the process of being replaced by the Composite Health Care System (CHCS). In effect, every transaction was converted from AQCESS to CHCS during the period involved in this study. CHCS is designed to be a fully integrated clinical and administrative automated information system that incorporates a broad range of capabilities to improve health care cost management, increase access to care, and improve the quality of care.

The CHCS is intended to integrate information on each service ordered for the patient. This provides the clinician the opportunity to link clinical interventions and treatment outcomes using information obtained by accessing the various modules (ancillary services, patient appointment and scheduling, physician outpatient order entry, managed care program support, results retrieval, and electronic mail). Consequently, the CHCS should enable the provider to receive information on which to base clinical judgements more rapidly than manual methods, potentially reducing unnecessary care, and minimizing duplicate or inappropriate tests, medications, or procedures.

As a result, the CHCS is designed to facilitate concurrent and retrospective review of resource use and treatment patterns. This leads to development of practice standards and treatment protocols to improve the effectiveness of care delivery. By capturing information on the individual treatments, tests, and procedures performed,

it is possible to understand better the actual costs associated with the specific care provided to a patient. The clinician is able to receive interactive feedback on the cost of care they are prescribing.

The CHCS does not currently allow preadmission processing to occur without modifying the patient database. As a Navy Standard System, system improvement requests must be recommended and approved at multiple levels outside the Naval Medical Center Portsmouth span of control. To date, system improvement requests to modify the software to allow for true preadmission processing have not been adopted or funded.

To avoid unnecessary errors and the validation and corrections, the Naval Medical Center Portsmouth admissions office elected to enter patient admission information (regardless of ancillary services being provided before the day of admission) into CHCS between midnight of the day before the patient is actually admitted and the time of the admission. In other words, a patient scheduled for admission on May 3 is unable to be entered into the system until after midnight May 2. This means work cannot be completed before the day of admission thereby defeating the purpose of the preadmission program as it relates to data entry.

Unaffected by the automated transition process was the requirement to obtain authorization for patient admission

from the third party payer within the payer-specified notification time. Consequently, the rate of denial of admissions was expected to remain relatively constant under CHCS if the pre-admission certification process was not improved.

Under AQCESS and CHCS, the admission of a patient generates six patient index cards that are distributed to various departments in the hospital. One card is forwarded to the third party billing and collection office through the collection agent. Upon discharge of the patient, a second card is attached to the Admissions/Disposition Report and is forwarded to the third party billing and collection office for preparation of the patient bill.

However, the third party billing and collection office uses the Admission/Disposition Report to generate the bill, in lieu of the CHCS-generated patient index cards. Based on 2,000 admissions per month and 2 cards per patient admission (one at the time of admission, the other attached to the Admissions/Disposition Report at the time of discharge), over 48,000 cards were unnecessarily printed for the third party collection office. This demonstrates an operational inefficiency to be addressed using a system improvement request to the CHCS. Reducing the number of patient index cards provide opportunity for the hospital to seek alternatives for use of the funds.



When a credentialed provider determines that admission to the hospital is necessary, the Admission Authorization (NAVHOSP form 6300/7) and Insurance Information (DD-2569) are forwarded to the preadmission certification processor. For routine preadmissions (Appendix H, Process Four), information on the DD-2569 is verified while the patient is present. This improves accuracy and provides additional opportunity for the preadmission certification processor to obtain needed information directly from the patient before calling the third party payer. Using Interqual ISD-A guidelines, the potential admission is screened for appropriateness.

When patients are admitted through the emergency room (Appendix H, Process Four-A), the preadmission certification processor verifies the admission diagnosis and the third party payer information with the patient or designee on the hospital ward. Once the information is obtained, the third party payer is contacted and the procedure mirrors that of the generic admission. Depending on the specific third party carrier requirements, the preadmission certification processor has 24 to 48 hours to obtain authorization for the emergency admission.

Patients presenting to the ambulatory procedure unit complete a preadmission packet up to 30 days in advance of the scheduled procedure (Appendix H, Process Four-B). The preadmission certification processor reviews the daily

ambulatory procedure log to validate the admitting diagnosis for patients with third party insurance. Approximately one week prior to the scheduled procedure date, the preadmission certification processor contacts the third party payer for authorization for the procedure. Most third party payers do not require an admission authorization for their subscribers if the hospital stay is expected to be less than 23 hours. If a longer stay is necessary, the patient is admitted to the hospital from the ambulatory procedure unit and the generic admission procedures are followed.

Correlation between the number of admissions authorized by the third party payers and the actual payment of claims by those payers has not been established because the processing time varies by payer. Because statistical significance has not been determined, the experiences found in the extremely small sample size are unable to be applied to the population.

The Naval Medical Center Portsmouth Board of Directors' active support of the preadmission certification program has increased awareness of the need to improve on this and other utilization management tools such as case management. Clinical departments that provide cost effective health care have received money from the Command to use as they deem necessary. To further the utilization review process, successes can be published in the Plan of the Day, Departmental and Directorate minutes, and recognized at

Command award ceremonies.

An outgrowth of preadmission certification process implementation has been patients advising their third party carriers of pending hospital admissions. Historically, patients eligible for care in a DoD facility have been reluctant to engage in discussions about insurance.

One limitation of this study was the exclusion of outpatients. In a study of preadmission certification processes, the outpatient environment is the initial entry point for the vast majority of admissions. Failure to include this population in the study precludes discovery of additional operational inefficiencies that could potentially provide additional sources of revenue for the medical center and is an area for additional investigation.

Another limitation is the lack of coordinated case management at Naval Medical Center Portsmouth. The economic efficiencies required by third party payers means the appropriate level of care must be provided in the most appropriate setting for the delivery of that care. A case manager works closely with credentialed providers, registered nurses, discharge planners, social workers, dietitians, chaplains, and others to facilitate the patient transition from outpatient care to inpatient admission and back to outpatient treatment. An effective case management program may produce cost savings by employing utilization management tools.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

The purpose of this research study was to analyze and evaluate the Naval Medical Center Portsmouth preadmission certification program for compliance with utilization review and utilization management tools.

The research revealed the preadmission certification process had several systemic inefficiencies. Departments accepted partial ownership of the preadmission process because there was a lack of knowledge and understanding regarding other department needs. Additional problems included ineffective interdepartmental communication, physical and artificial barriers, and the lack of automation support.

The presence of the Preadmission Certification Processor has improved Naval Medical Center Portsmouth's reimbursement level from third party payers. Patients are admitted for medically necessary care following application of predetermined admission criteria to the patient care episode. Responsibilities of the preadmission certification processor include obtaining third party payer authorization for patient admissions, monitoring third party payments to ensure maximum reimbursement is received, and serving as the central point of contact for third party payers.

Communication has improved between physicians, utilization management and utilization review, patient administration, and resource management. The parties are willingly and openly discussing issues that cross professional and personal boundaries in the health care delivery system.

The Internal Medicine Department uses a patient care conference to address patient needs. Participants include registered nurses, senior internal medicine residents, floor, utilization review coordinator, dietician, social worker, chaplain, and discharge planner. Ad hoc representation is also solicited to provide additional insight to patient care issues. The conferences are held weekly to ensure all patient needs are addressed.

This process should be exported to other clinical specialties to improve overall delivery of care at Naval Medical Center Portsmouth. One way to assist this process is to directly involve the internal medicine physicians in inservice education programs delivered through the medical staff meetings. The registered nurse, as the coordinator for inpatient care is instrumental in the identification and resolution of patient care utilization management issues.

The Naval Medical Center Portsmouth limits the preadmission certification process to patients with third party insurance because reimbursement may be available. This necessarily minimizes the discovery of inappropriate

admission requests for patients without insurance. To improve preadmission certification operations Interqual ISD-A preadmission review criteria should be applied to all categories of patients and payers.

The preadmission certification processor calls or visits insurance company representatives to ascertain their requirements and procedures (Salmon and Alderfer 1990). Visiting the business offices of other health care delivery organizations provides for observation of business practices and procedures which could be incorporated into the Naval Medical Center Portsmouth preadmission certification process. For example, the incorporation of resources, admissions, and utilization management components may facilitate implementation of the case management process.

Consideration should be given to implementation of total case management versus the fragmented process used today. Case managers are designed to work closely with the patient, the patient's family, and the health care providers to plan and arrange the needed care (Baschon 1992). Decisions are made as a team to ensure the patient receives the treatment that best meets the situation.

As a collaborative process, case management assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet health needs through communication using available resources to promote quality, cost-effective outcomes. As the link between the

individual, the providers, the payers, and the community, case management encourages appropriate use of medical facilities and services, improves the quality of care and maintains cost-effectiveness on a case-by-case basis.

The attention focused on the preadmission certification process has enabled the Naval Medical Center Portsmouth to identify multiple targets for improvement. Of specific note are the elimination of duplicate admission packages for active duty and non-active duty patients and reduction of the number of pages in each admission package by consolidating required notification forms.

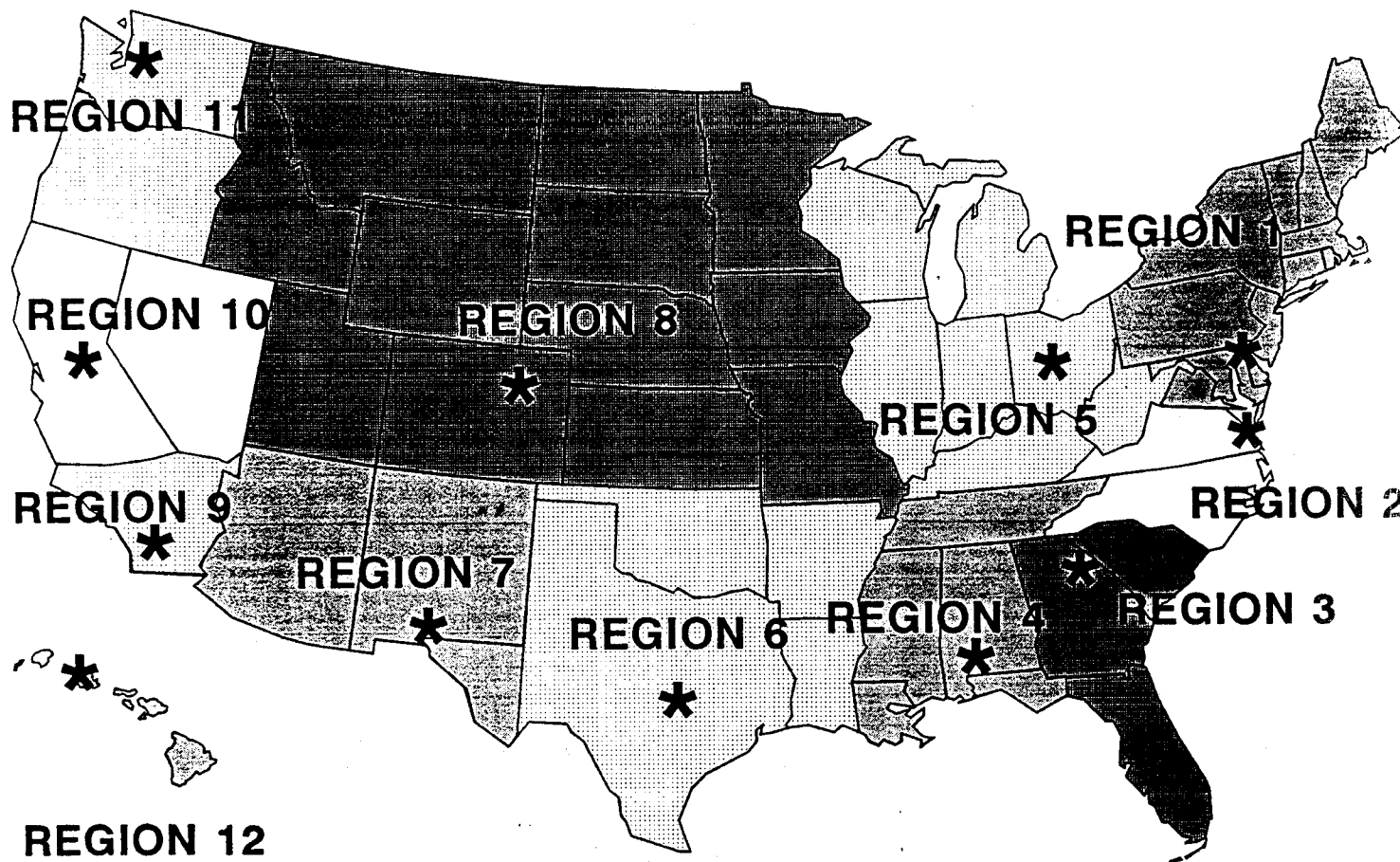
Additional study is needed to identify the long-term benefits of the preadmission certification process in terms of decreased lengths of stay, increased outpatient visits, and improved utilization of resources.

Health care reform is a challenge for all members of the health care team. Quality, cost, and access are the driving forces for health care reform. As the public becomes more educated in the fine points of health care delivery, they will abandon passivity and seek full health care disclosure. Economics and ethics are not mutually exclusive. Balancing the two will result from active collaboration among providers, patients, and payers. As the population ages and technological advances abound, the two will play more and more into every decision.

**APPENDIX A**

**LEAD AGENT REGIONS**

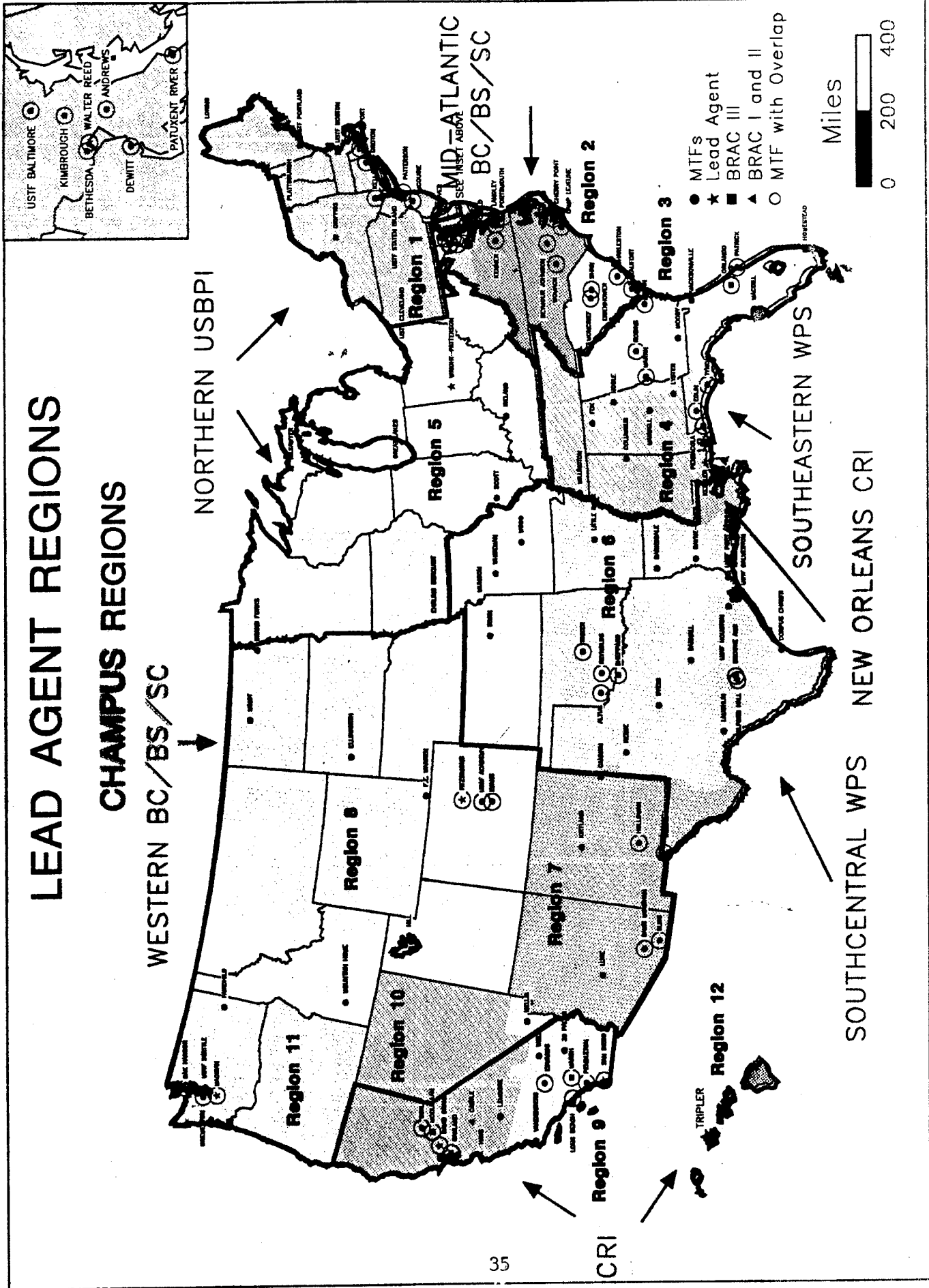




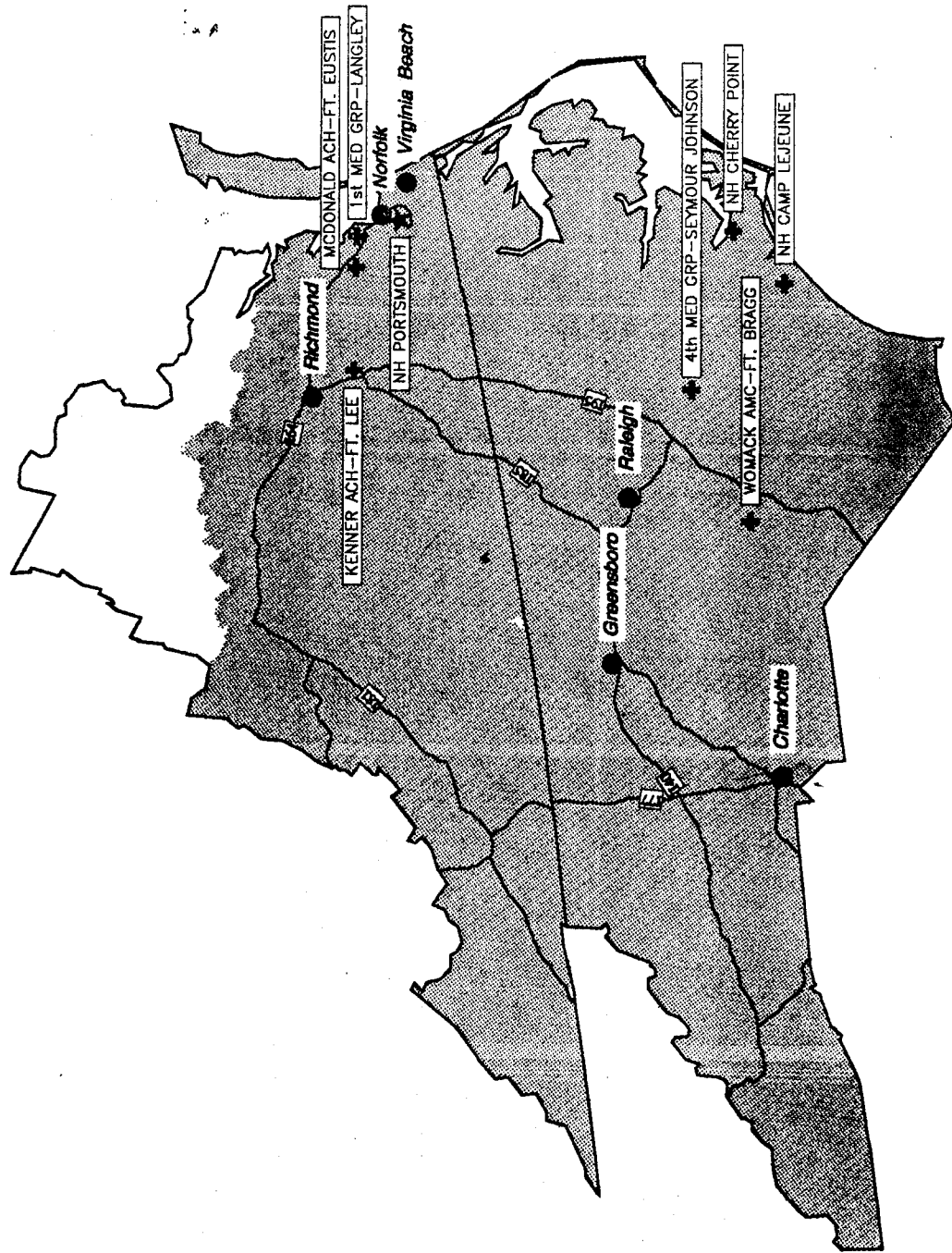
## **\*LEAD AGENT**

**The 12 geographic regions currently being organized by DOD and their lead agents are:**

- Region 1:** TriService Lead Agent (Chair rotates among three services) Walter Reed Army Medical Center (AMC), Washington, DC; National Naval Medical Center Bethesda, MD.
- Region 2:** Lead Agent Navy - Naval Medical Center (NMC) Portsmouth, VA.
- Region 3:** Lead Agent Army - Eisenhower Army Medical Center (AMC).
- Region 4:** Lead Agent Air Force - Keesler USAF Medical Center, MS.
- Region 5:** Lead Agent Air Force - Wright-Patterson USAF Medical Center, OH.
- Region 6:** Lead Agent Air Force - Wilford Hall USAF Medical Center, Lackland AFB, TX.
- Region 7:** Lead Agent Army - William Beaumont AMC, Fort Bliss, TX.
- Region 8:** Lead Agent Army - Fitzsimons AMC, Denver, CO (no Navy facilities).
- Region 9:** Lead Agent Army - Naval Medical Center San Diego, CA.
- Region 10:** Lead Agent Air Force - David Grant USAF Medical Center, Travis AFB, CA.
- Region 11:** Lead Agent Army - Madigan AMC, Fort Lewis, WA.
- Region 12:** Lead Agent Army - Tripler AMC, Fort Shafter, HI.

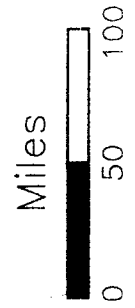
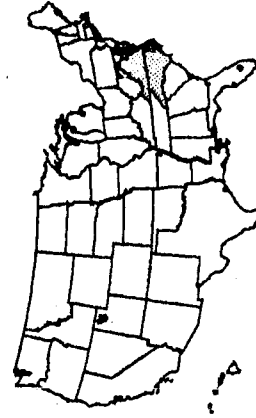


# REGION 2



## Legend

- Region 2
- States
- Interstates
- Major Cities
- MTFs
- Lead Agent

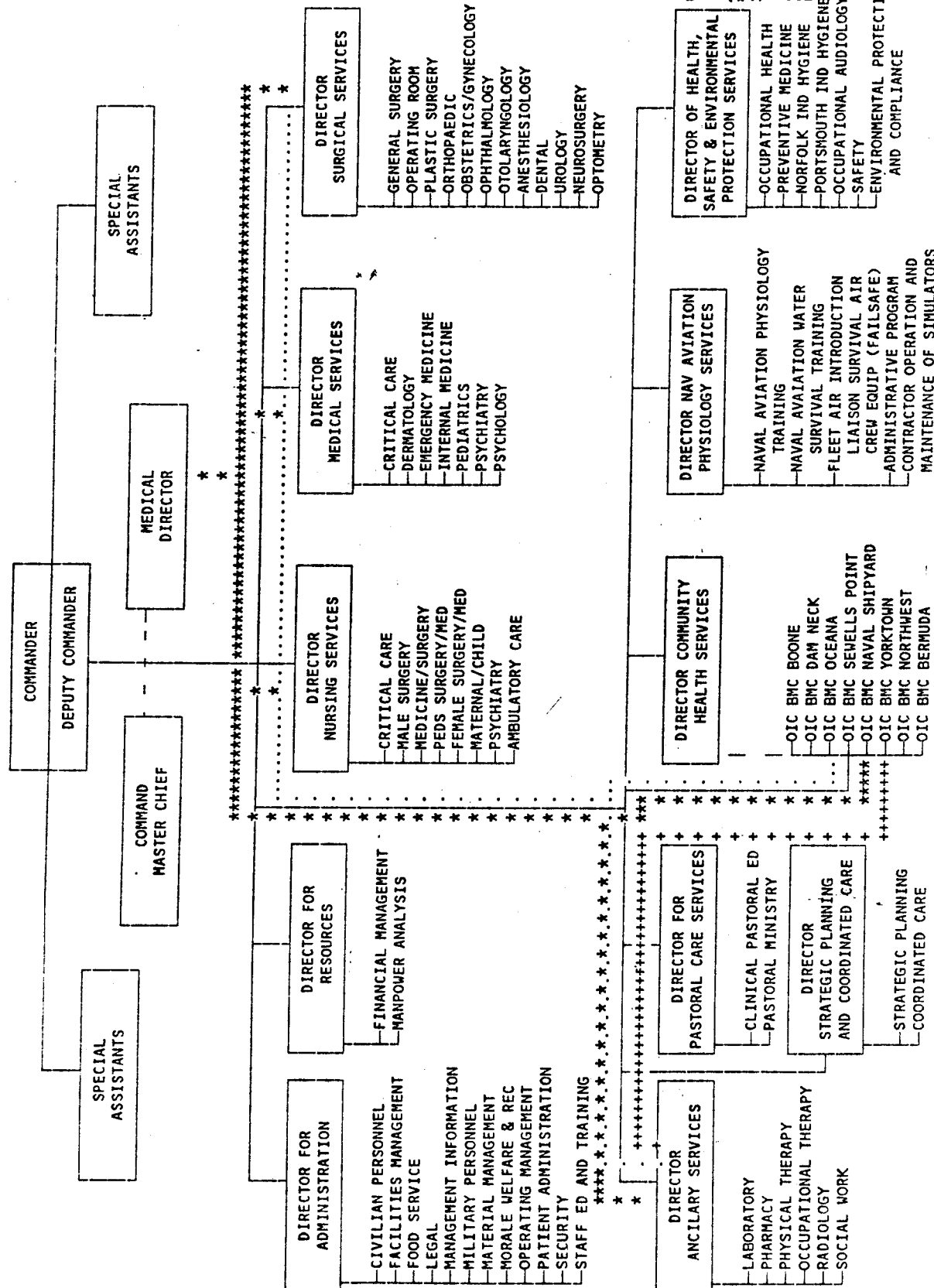


APPENDIX B

NAVAL MEDICAL CENTER PORTSMOUTH

ORGANIZATION CHART

20 APR 1992



CHIEF OF STAFF  
 D. B. LESTER  
 RADM, MC, USN  
 COMMANDER

--- = LINE CONTROL  
 --- = STAFF COORDINATION  
 \*\*\*\*\* = CLINICAL PROFESSIONAL RESPONSIBILITY  
 ..... = NURSING PROFESSIONAL RESPONSIBILITY  
 ++++++ = ANCILLARY PROFESSIONAL RESPONSIBILITY

## APPENDIX C

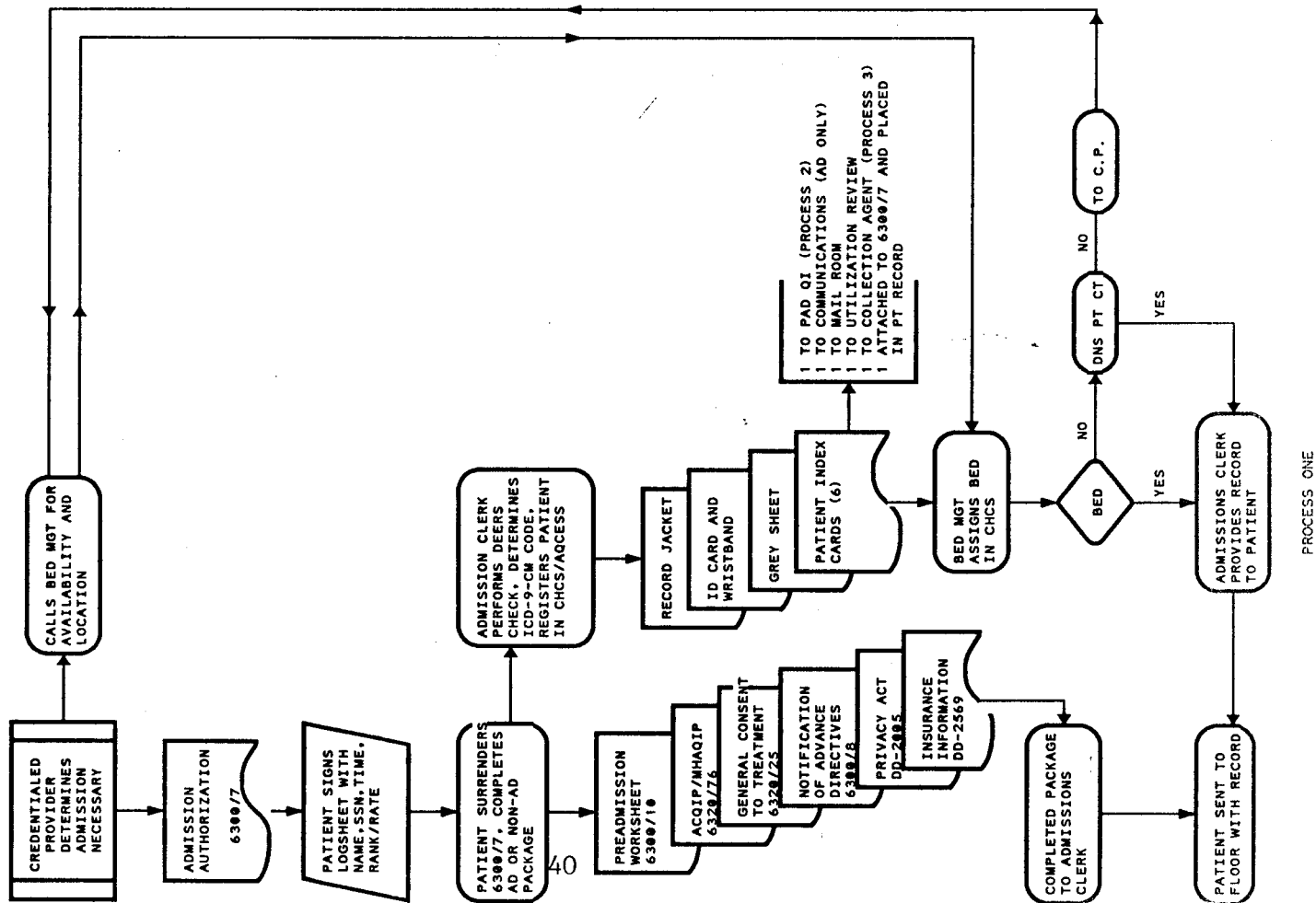
### ADMISSION PROCESS FLOW CHARTS

#### GENERIC ADMISSION (PROCESS ONE)

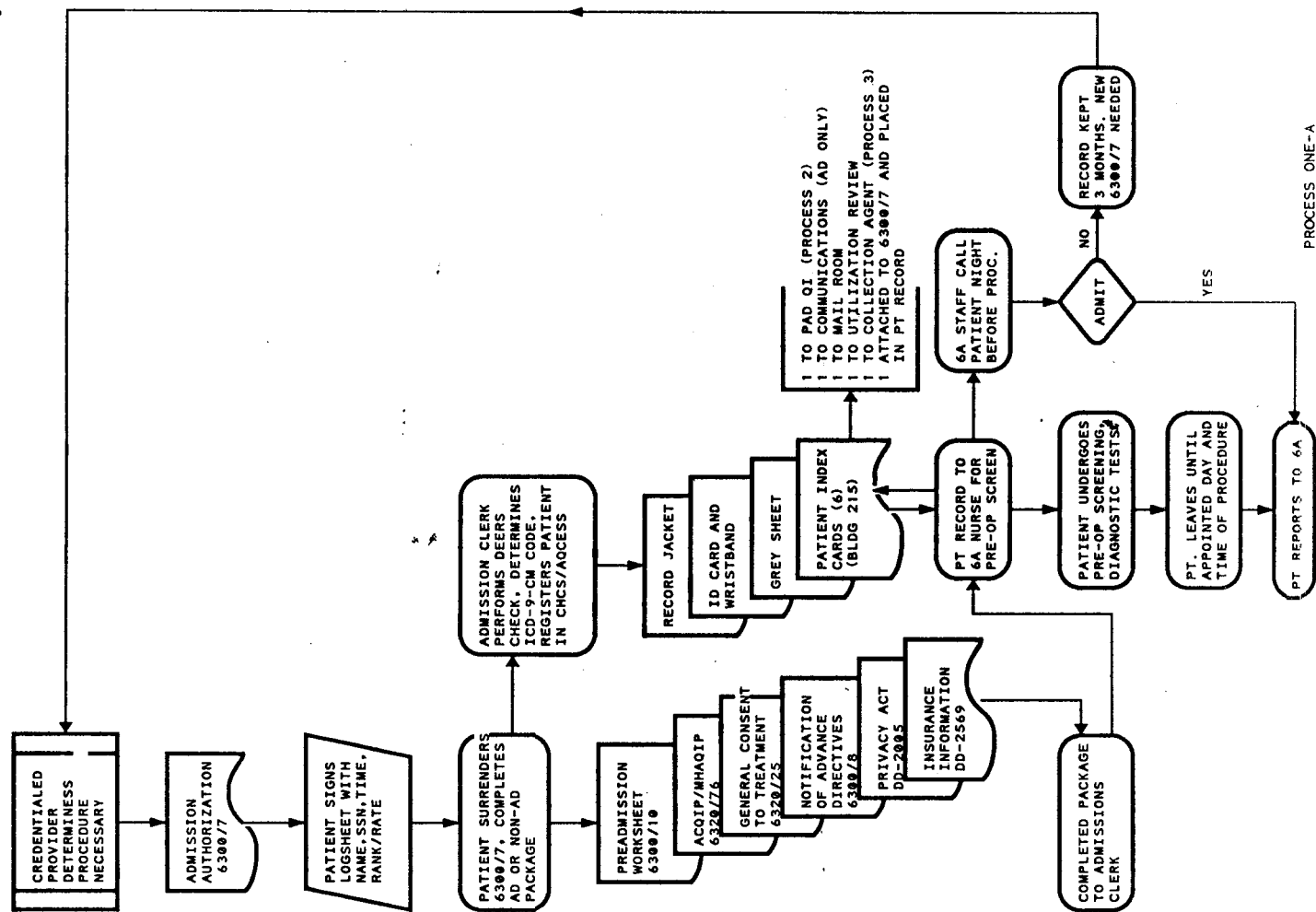
#### AMBULATORY PROCEDURE UNIT (PROCESS ONE-A)

#### LABOR AND DELIVERY (PROCESS ONE-B)

**AMBULATORY PROCEDURE UNIT**

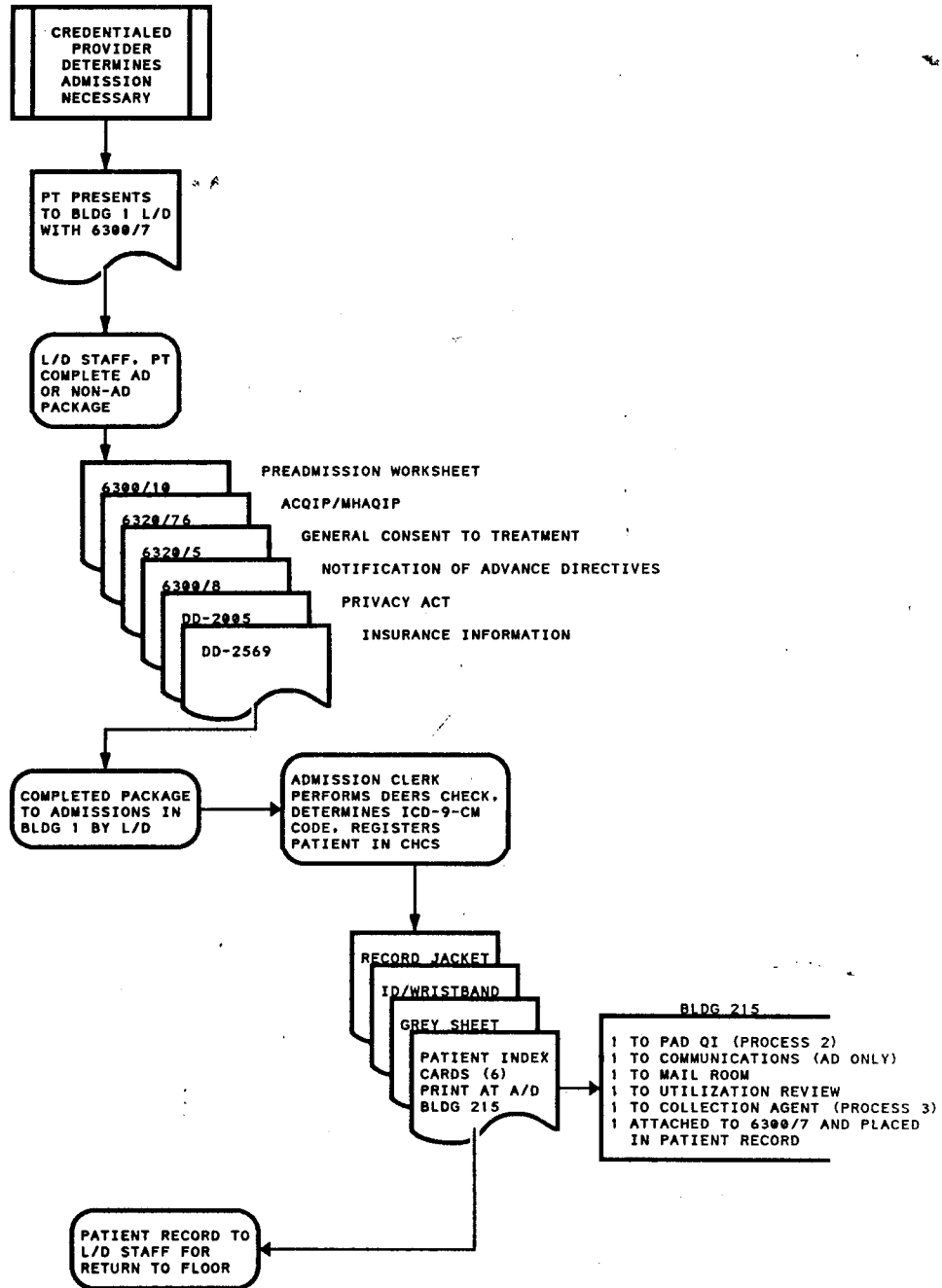


## PROCESS ONE



## PROCESS ONE-A

# LABOR AND DELIVERY ADMISSION PROCESS



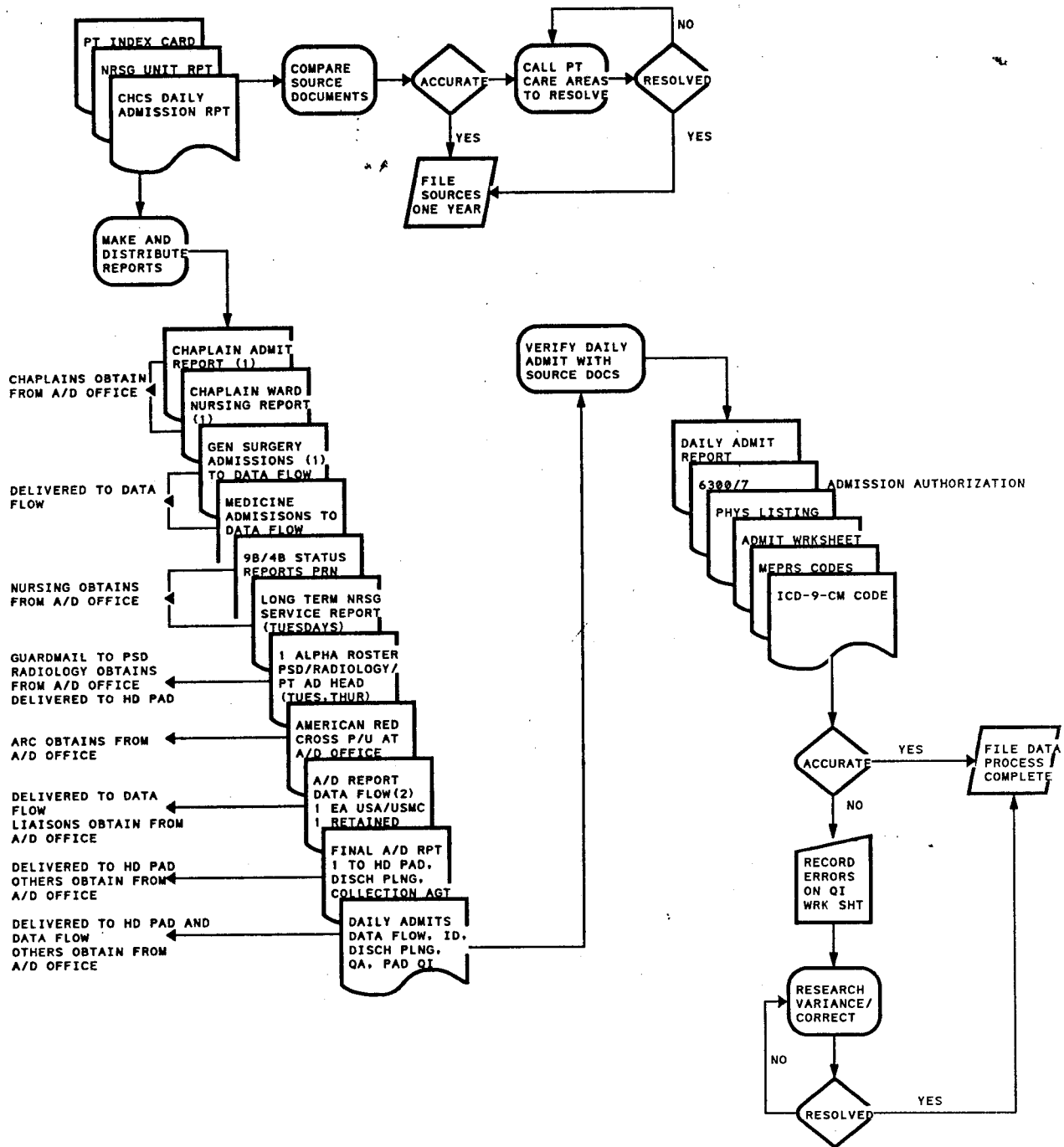


APPENDIX D

ADMISSIONS / DISPOSITIONS

QUALITY IMPROVEMENT PROCESS FLOW CHART (PROCESS TWO)

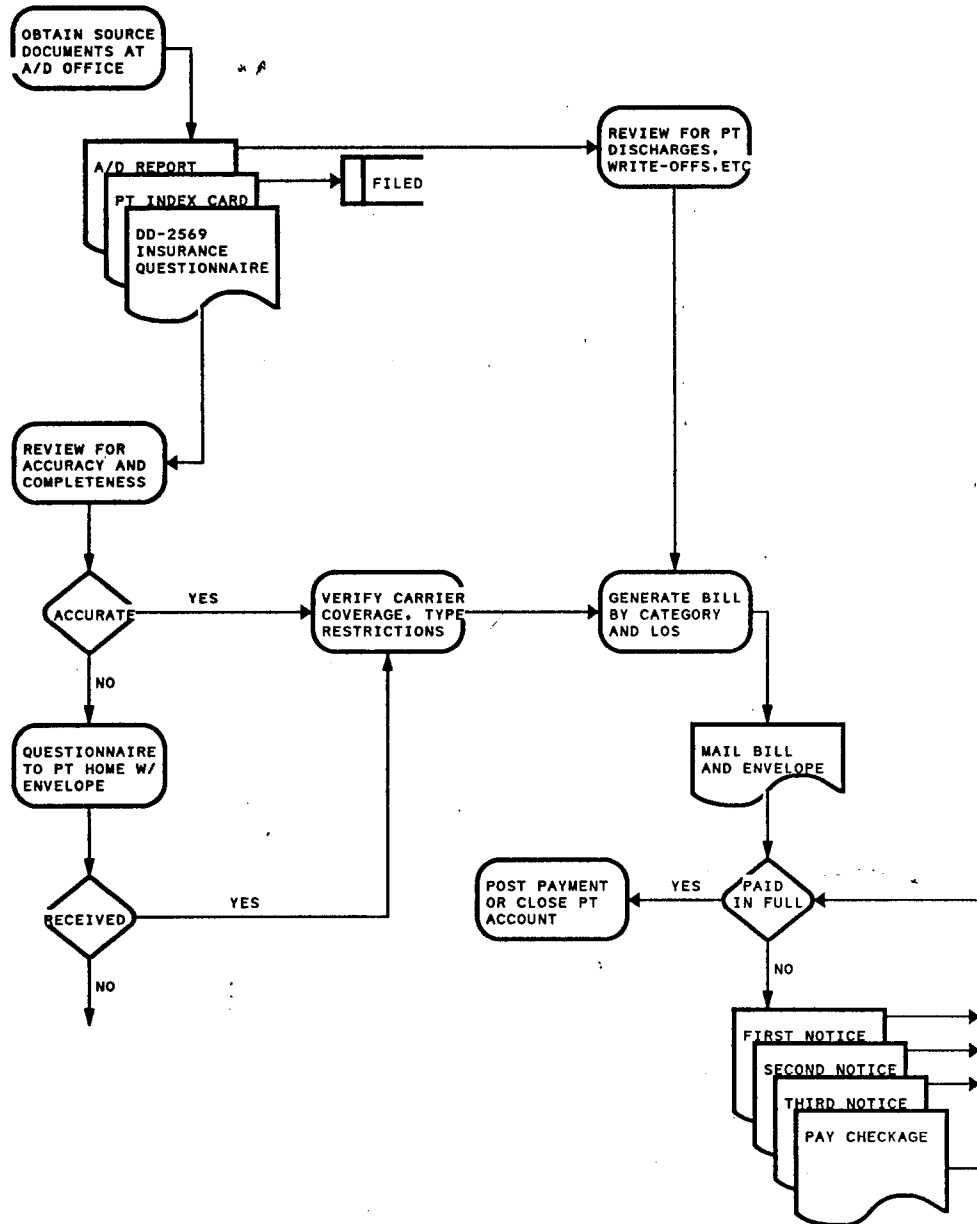
# ADMISSIONS / DISPOSITIONS QUALITY IMPROVEMENT PROCESS



## APPENDIX E

### BILLING AND COLLECTION PROCESS FLOW CHART (PROCESS THREE)

# BILLING AND COLLECTION PROCESS



APPENDIX F

COST BENEFIT ANALYSIS FOR

PREADMISSION CERTIFICATION PROCESSOR

7000  
0302  
27 Oct 93

MEMORANDUM

From: Head, Accounting Department  
To: Director for Resources/Comptroller  
Via: Deputy Comptroller

Subj: COST BENEFIT ANALYSIS FOR PREADMISSION CERTIFICATION  
PROCESSOR

Encl: (1) Third Party Collection Program - Report on Program  
Results

1. The highlighted areas of enclosure (1) represents the amount of insurance denials received from third party payers for Fiscal Years 1991 through 1993. Based on FY 92, 3.65% of every dollar billed was denied because insurance preadmission certification was not performed as required by the third party payers. Using FY 92's denial rate and multiplying that by the amount billed for FY 93, we can expect over \$300,000 of preadmission certification denials as the FY 93 accounts are liquidated.

2. After reviewing the preadmission certification denials that we have received this fiscal year, it is difficult to determine how much money this Command would have received had we performed the required preadmission certification. This is due to two reasons; (1) Other denials that were added into the preadmission certification code in the AQCESS system, because the system only allows for one denial code per account, (2) In some instances, third party payers will deny the entire claim because preadmission certification was not obtained. In the AQCESS system we used the preadmission certification code to write off the entire claim even though we did not expect to receive the entire amount billed.

3. Conservatively, we believe that approximately 70% of the denials are monies that this command would have received with the proper preadmission certification. With that, \$210,000 (\$300,000 times 70%) of third party reimbursement was lost to this Command in FY 93 because of preadmission certification process problems.

4. Based on this analysis, I recommend that we hire one GS-7/9 position to work in the Admissions Office to perform preadmission certifications. That individual will work directly for the Head, Patient Billing and Collection. In addition to the benefits gained from improving the preadmission certification process, we believe the presence of a trained third party reimbursement position in the Admissions Office, will improve the insurance information obtained from the patient for subsequent billing.

Subj: COST BENEFIT ANALYSIS FOR PREADMISSION CERTIFICATION  
PROCESSOR

5. I am available to discuss this at your convenience.

  
S. P. HARRY

# THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS

REPORT CONTROL SYMBOL: DD-HA (Q) 1854

DATE: 15 OCT 1993

- 1) QUARTER ENDING: SEP 1993
- 2) REPORTING MEDICAL TREATMENT FACILITY (MTF): NAVMEDCEN PORTSMOUTH
- 3) DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO: 0124

## PART I

(4) REPORTING PERIOD	(5) NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS	(6) NO. OF CLAIMS	(7) NO. OF COLLECTIONS	(8) NO. OF CLAIMS DIVIDED BY DISPOSITIONS	(9) TOTAL \$ AMOUNT BILLED CHARGES
CURRENT FY: 93	14202	2071	890	14.58 %	8342594.50
PY-1: 92	15280	2586	1739	16.92 %	6625141.00
PY-2: 91	15966	1771	1020	11.10 %	5267659.00

(10) # ADJUSTMENTS FOR INVALID CHARGES	(11) # AMOUNT COLLECTED PY-2	(12) # AMOUNT COLLECTED PY-1	(13) # AMOUNT COLLECTED CURRENT FY	(14) # AMOUNT REMAINING UNCOLLECTED (9) - (10 + 11 + 12 + 13)
CURRENT FY: 93	4233547.78	NO ENTRY	NO ENTRY	1960462.68
PY-1: 92	4356615.95	NO ENTRY	1536063.82	590352.23
PY-2: 91	3849623.58	791128.89	593894.98	33011.55

- NOTES: A - AMOUNTS REPORTED IN ITEM 10 FOR EACH FISCAL YEAR SHALL EQUAL THE SUBTOTAL FOR LINES 7 - 12 IN PART II, FOR THE RESPECTIVE FISCAL YEARS.
- B - AMOUNTS REPORTED IN ITEM 14 FOR EACH FISCAL YEAR SHALL EQUAL THE SUBTOTAL FOR LINES 1 - 6 IN PART II, FOR THE RESPECTIVE FISCAL YEARS.



5) DISTRIBUTION OF REMAINING  
UNCOLLECTED AMOUNTS

(16) UNCOLLECTED AMOUNTS SUBDIVIDED BY FY (\$)

REASON CODES	A. FY 93	B. FY 92	C. FY 91
OPEN CLAIMS	1 2148584.04	142109.00	0.00
INVALID DENIALS	2 34890.44	8939.75	12364.14
	3 69393.00	13319.00	10251.00
	4 .00	.00	368.00
	5 .00	22432.00	31356.00
	6 .00	.00	.00
TOTAL REASON CODES (1 THROUGH 6)	2252867.48	186799.75	54339.14
INVALID BILLED CHARGES			
	7 358883.51	331803.88	173895.57
	8 373307.69	876087.00	905470.53
	9 3216817.24	2766951.01	2408659.40
	10 12119.00	101057.00	73517.00
	11 168136.90	236026.31	233741.94
	12 .00	0.00	0.00
TOTAL REASON CODES (7 THROUGH 12)	4129264.34	4311925.20	3795284.44

EXPLANATION OF REASON CODES FOR UNCOLLECTED AMOUNTS

- OPEN CLAIMS (REQUIRES ADDITIONAL FOLLOW-UP ACTION BY MY MEDICAL TREATMENT FACILITY FOR RESOLUTION)
- REASON CODES 2-6. THIRD PARTY REDUCED/DENIED PAYMENT FOR INVALID REASONS (REQUIRES ADDITIONAL DEBT COLLECTION/LEGAL ACTION)
- MTF NOT A PARTICIPATING HOSPITAL
- PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES
- PATIENT HAD NO OBLIGATION TO PAY
- INSURED PAID PATIENT DIRECTLY
- OTHER (EXPLAIN)

REASON CODES 7-12. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS

- AMOUNT OF COVERAGE (I.E. PLAN PAYS LESS THAN 100%)
- PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED
- MEDICARE, CHAMPUS, INCOME SUPPLEMENTAL PLANS
- HEALTH MAINTENANCE ORGANIZATION (I.E. NONEMERGENCY OUT-OF-PLAN CARE NOT COVERED)
- MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES (I.E. PREADMISSION SCREENING, CONCURRENT REVIEW, SECOND SURGICAL OPINIONS, ETC.)
- OTHER (E.G. THIRD PARTY PROVIDED LOWER PREVAILING RATE VS. AMOUNT BILLED)

REMARKS: C - ALL ACTIVITY FOR AMOUNTS CLAIMED AND COLLECTIONS SHALL BE REPORTED IN THE FISCAL YEAR THAT THE SERVICES WERE RENDERED. REGARDLESS OF THE YEAR THAT PAYMENT IS RECEIVED, THIS REQUIRES CUT-OFF BILLING FOR ALL INPATIENTS AT FISCAL YEAR END.

D - EACH QUARTERLY REPORT SHALL BE CUMULATIVE FOR THE CURRENT AND PRIOR FISCAL YEAR.

APPENDIX G

PREADMISSION CERTIFICATION PROCESSOR

POSITION DESCRIPTION

## PREADMISSION CERTIFICATION PROCESSOR

### I. INTRODUCTION

This position is located in the Patient Billing and Collection Division, Accounting Department, under the cognizance of the Director for Resources at Naval Medical Center, Portsmouth, Virginia. The incumbent is responsible for the preadmission certification process of the Third Party Collection Program (TPCP).

### II. MAJOR DUTIES:

- \* Serves as the MTF representative and point of contact to secure requisite hospitalization authorization from third party payers.

- \* Coordinates with physicians, clinics and services and the medical screening process to assist patients in preadmission certification for hospitalization. Advises insurance company of impending patient admissions and obtains authorization for treatment under the respective insurance coverage prior to admission.

- \* After consultation with the admitting physician, provides rationale/justification for hospitalization, the services to be furnished and the treatment to be rendered, and the projected length of hospitalization to the insurance companies concerned, by effectively applying the knowledge, training, and experience of an individual with a strong medical background (i.e., Registered Nurse, Licensed Practical Nurse) to the situation at hand.

- \* Verifies diagnosis or other pertinent clinical information which was not previously furnished or available. Negotiates with the insurance company regarding services to be authorized.

- \* Coordinates with the Utilization Review staff in connection with discharge planning and case management and performs preadmission, admission, and continued stay review of all elective, urgent, and emergency admissions which are covered by the TPCP.

- \* Assists physicians and hospital staff in interpreting guidelines and criteria for patient care prescribed by third party payers.

- \* Assists in development of protocols and procedures applicable to utilization management efforts dealing with third party reimbursements.

- \* Provides required data for various reports which have been established to allow the MTF to manage the admission screening and control process as it relates to the TPCP.

\* Reviews all preadmission certification denials of payment in the light of guidance established in the implementing instructions and makes recommendations concerning their disposition.

\* Performs administrative procedures and screening reviews for admission to the Medical Center per established admission criteria.

\* Uses preestablished (Interqual IS-SI) criteria to make admission determinations with regard to the efficient and effective allocation of medical resources.

\* Communicates directly with the Utilization Review staff to determine if hospitalization is medically necessary.

\* Obtains accurate admitting diagnosis that appropriately reflects the reason the patient is to be admitted and receives physicians orders to attach to admission paperwork.

\* Determines admission insurance status and coordinates payer authorization and certification for care.

\* Identifies and forwards to Utilization Review or Risk Management questionable admission patterns and trends, noted or suspected to be utilization or quality of care related (such as identification of patients to be the subjects of morbidity and mortality reviews, and patients readmitted from a complication of a prior admission).

\* Works in conjunction with Patient Administration Department staff and the health care team members to facilitate the movement of patients through the administrative aspects of the system (e.g., Admission, DRG Classification, Medical Boards, etc).

#### **FACTOR ONE: KNOWLEDGE REQUIRED**

\* The incumbent must be an individual with a strong medical background (i.e., Registered Nurse, Licensed Practical Nurse) with significant experience in billing and collecting insurance claims.

\* Knowledge of established professional medical principles, practices, and procedures required to provide administrative medical care to patients with a wide variety of conditions.

\* Knowledge of missions, organizations, programs, and requirements of a health care delivery system.

\* Knowledge of NMC, Portsmouth's mission, organizations, programs and the interrelationship of medical and administrative departments.

\* Knowledge of regulations and standards of various regulatory

and credentialing groups, such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Department of Defense (DOD), and Inspector General (IG).

- \* Knowledge of code of ethics and confidentiality.
- \* Basic knowledge of government-wide, agency, facility systems and requirements in various administrative areas, such as budget, personnel, and procurement.
- \* Knowledge of the different functions and motivations of various groups within the health care organization and the ability to communicate effectively with each in order to gather information, present recommendations, and coordinate services.
- \* Ability to analyze problems and present written, oral, and computer generated recommendations, taking into full consideration the wide range of factors and requirements which affect the management of a health care delivery system.
- \* Knowledge of statistical methods, analytical techniques, decision theory, and deductive reasoning, ICD-9-CM, Current Procedural Terminology (CPT-4) classifications, Interqual IS-SI protocols, and medical records organization.
- \* Knowledge of predetermined criteria concerning such events as length of stay, Diagnosis Related Groups (DRGs), and standard of care policies.
- \* Knowledge of current medical treatment record maintenance and Utilization Review practices to assure appropriateness of admission.
- \* Knowledge of medical forms and documentation, such as progress notes, operative reports, narrative summaries, logs, consults, and computerized data.
- \* Ability to: determine appropriate/inappropriate medical care is rendered, identify problems, follow, resolve, and track recognized events for referral to the QA&I/UR/RM process, as appropriate, for investigation.
- \* Knowledge of policies and procedures governing medical actions, such as medical boards, to assure proper allocation of medical center resources.
- \* Knowledge of computer input and word processing, data analysis and techniques for testing the reliability of clinical data to identify patterns, trends, or issues of significance.
- \* Knowledge of medical terminology, anatomy and physiology of sufficient depth to communicate orally and in writing with the medical staff and representatives of insurance companies concerning the medical condition of the patient, the need for treatment or the length of hospitalization. Ability to negotiate

with the third party insurers to obtain precertification, avoid assessment of penalties, and reach agreement on the parameters of insurance coverage.

#### **FACTOR TWO: SUPERVISORY CONTROLS**

\* The Preadmission Certification Processor works under the direct supervision of the Head, Patient Billing and Collection Division who sets overall objectives and establishes the guidelines for the program. Incumbent independently plans and carries out assignments per the guidance provided and the standards of a professional nurse. The work is evaluated for adherence to these standards and guides and on how the objectives have been met.

#### **FACTOR THREE: GUIDELINES**

\* Guidelines consist of established policies, objectives, procedures and accepted medical practices and protocols. Incumbent uses judgement, initiative, and resourcefulness in determining extent to which existing guidelines apply and in developing supplemental guides to augment program objectives.

\* Guidelines consist of JCAHO regulations, DOD/BUMED instructions, NMC, Portsmouth, directives, Utilization Review Plan, QA&I/RM plans, the Manual of the Medical Department, International Classification of Disease (current edition), Current Procedural Terminology (CPT), Journal of the American Records Association, Quality Assurance Professional Journals, and procedures of statistical analysis.

#### **FACTOR FOUR: COMPLEXITY**

\* Incumbent interfaces with representatives of insurance carriers concerning precertification of patients and penalty avoidance; with patients, their families, and the medial staff to obtain information concerning the medical condition or treatment. Based on the professional knowledge of nursing and medical treatment procedures, and within the scope of the TPCP, the incumbent resolves issues of various degrees of difficulty, ranging from routine to complex, concerning the medical treatment provided or contemplated. In case an incumbent cannot provide the answer, a physician can be consulted.

#### **FACTOR FIVE: SCOPE AND EFFECT**

\* The purpose of the Preadmission Certification Processor is to obtain precertification and to coordinate with the insurance carrier on a mutually agreed upon treatment which meets the requirements of the insurance coverage. The performance of this work maximizes the reimbursements for medical treatment collected

from insurers and indirectly benefits the MTF concerned which will receive these funds.

#### **FACTOR SIX: PERSONAL CONTACTS**

\* Personal contacts are with the medical and administrative staff of the MTF, with patients and their families, and with Federal and commercial insurance reviewers and various other representatives of third party insurance companies.

\* Inter-agency contacts are with the health care team comprised of physicians, nurses, social workers, and representatives of ancillary services, physician advisors, legal staff, QA&I/RM coordinators, Patient Administration staff, Medical Director, Deputy Commander, and various military installations, medical board staff, formal hearing board staff, and staff from local agencies, such as the Veterans Administration, and patients. Frequently, the nature of the contacts require tactful handling of people and information.

#### **FACTOR SEVEN: PURPOSE OF CONTACT**

\* Purpose of contacts is to obtain precertification for care, or agreement on the type of insurance coverage for care that has already been rendered. Frequently the incumbent must persuade or influence the insurance company representative concerning the need and appropriateness of the medical treatment for meeting insurance coverage parameters for payment. Contacts with families, patients, and the medical staff of the MTF are primarily to obtain information or accomplish health care planning.

\* Personal contacts involve the exchange of confidential patient information, identification of problems and their resolution. The incumbent deals in situations where persons may vary from cooperative to unreceptive.

#### **FACTOR EIGHT: PHYSICAL DEMANDS**

\* Work is sedentary but may require some walking, bending, and carrying light items such as books or file folders.

\* The work requires extensive reading, writing, and data input with analysis and generation of reports via computer.

#### **FACTOR NINE: WORKING CONDITIONS**

\* The work is performed within a medical center setting. Requires working in patient care areas, typical office settings, physician offices, patient administration department, or other areas, as necessary.

APPENDIX H

PREADMISSION CERTIFICATION FLOW CHARTS

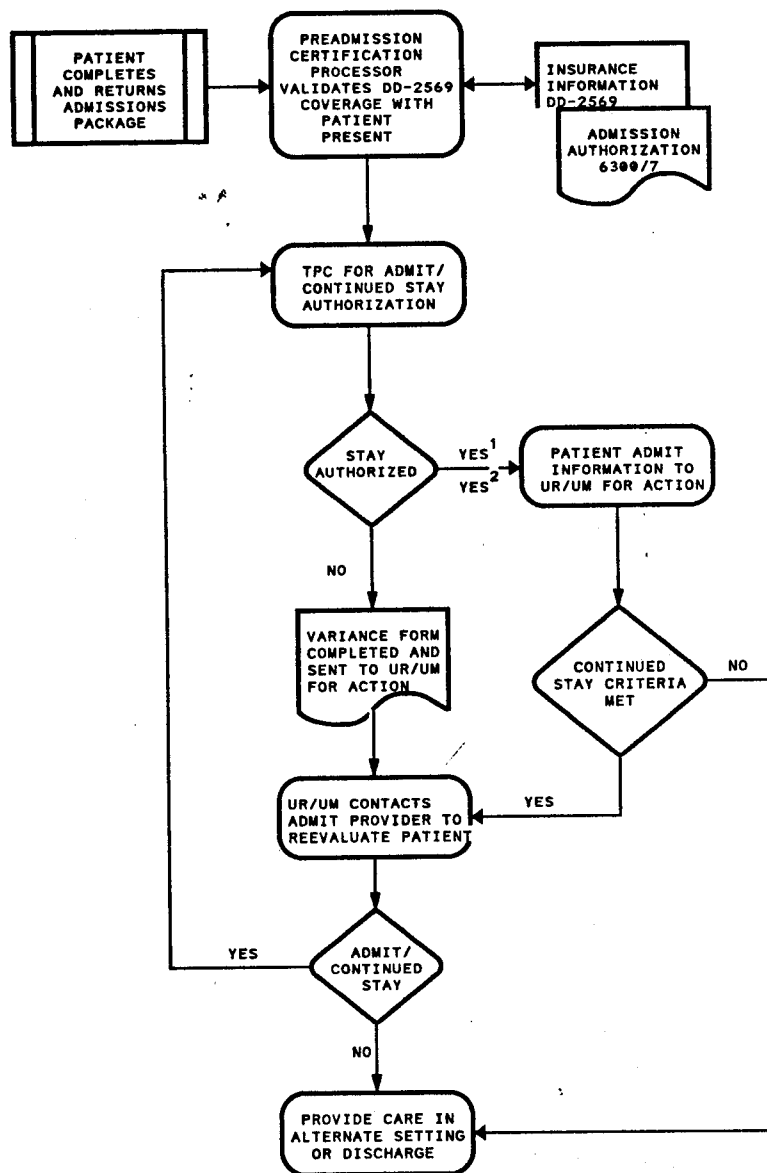
GENERIC ADMISSIONS (PROCESS FOUR)

EMERGENCY ADMISSIONS (PROCESS FOUR-A)

AMBULATORY PROCEDURE UNIT ADMISSIONS (PROCESS FOUR-B)



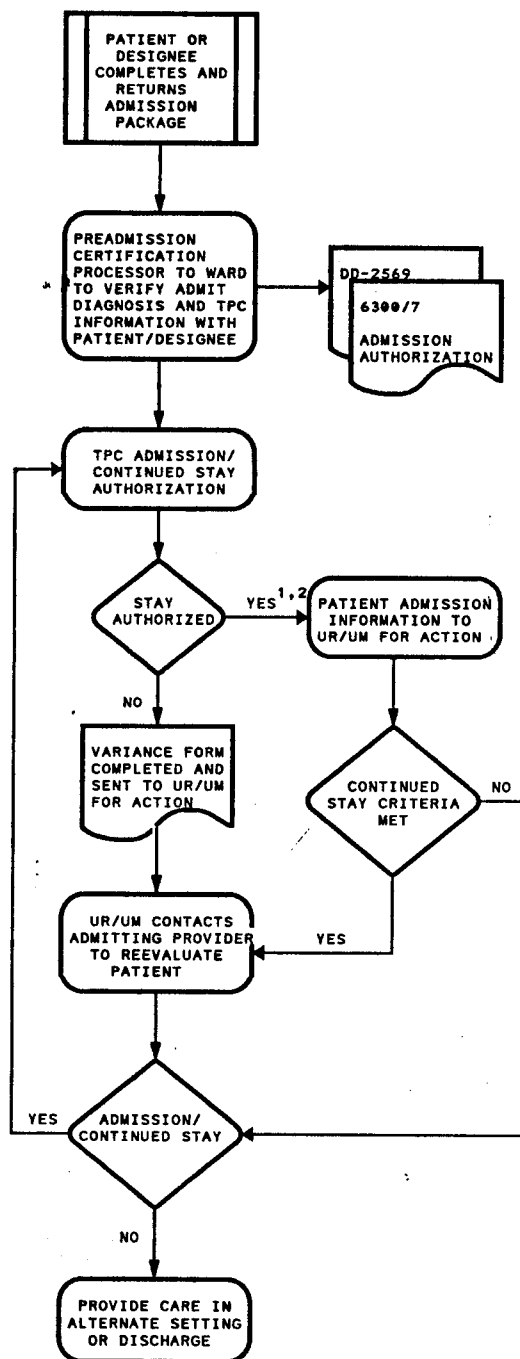
GENERIC ADMISSION PROCESS FOR  
PREADMISSION CERTIFICATION PROCESSOR



YES<sup>1</sup> ADMISSION AUTHORIZED (LETTER OF COVERAGE CONFIRMATION SENT TO HOSPITAL)

YES<sup>2</sup> ADMISSION DENIED BUT PROVIDER DEEMS ADMISSION NECESSARY

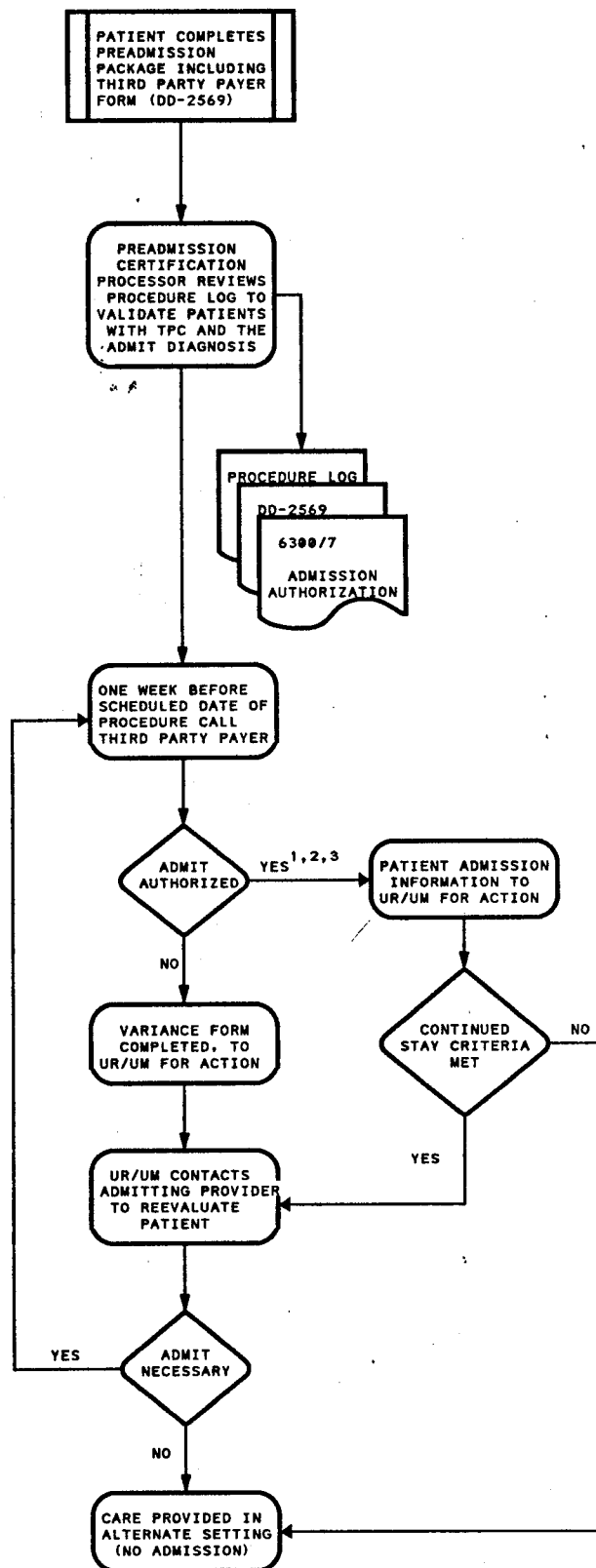
EMERGENCY ADMISSION PROCESS FOR  
PREADMISSION CERTIFICATION PROCESSOR



YES<sup>1</sup> ADMISSION AUTHORIZED (CONFIRMATION LETTER SENT TO HOSPITAL)

YES<sup>2</sup> ADMISSION DENIED BUT PROVIDER DEEMS ADMISSION NECESSARY

AMBULATORY PROCEDURE UNIT PROCESS FOR  
PREADMISSION CERTIFICATION PROCESSOR



YES<sup>1</sup> ADMISSION AUTHORIZED (TYPICALLY NOT REQUIRED FOR STAYS UNDER 23 HOURS)

YES<sup>2</sup> ADMISSION AUTHORIZED (CHANGES TO GENERIC ADMISSION FOLLOW-UP PROCEDURES)

YES<sup>3</sup> ADMISSION DENIED BUT PROVIDER DEEMS ADMISSION NECESSARY

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